State of Vermont
Agency of Human Services

GLOBAL COMMITMENT TO HEALTH
11-W-00194/1

Revised Evaluation Plan

March 2008

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I. INTRODUCTION

On September 30, 2005, the Vermont Legislature, through its Joint Fiscal Committee, granted conditional approval for the State to begin implementation of the Global Commitment to Health Demonstration Program. The Legislature gave full approval for participation on the waiver on December 13, 2005. The Global Commitment to Health is a Demonstration Initiative operated under the Section 1115(a) waiver and now encompasses all of Vermont's Medicaid programs with the exception of the Long Term Care Waiver, the State Children's Health Insurance Program and the Disproportionate Hospital Payments.

The Global Commitment Waiver provides the state with the ability to be more flexible in the way it uses it Medicaid resources. Examples of this flexibility include new payment mechanisms (e.g. case rates, capitation, combined funding streams, incentive reimbursements) rather than individual fee-for-service payments, flexibility to pay for services not traditionally reimbursable through Medicaid (e.g. pediatric psychiatry consultation) and investments in programmatic innovations (e.g., the Vermont Blueprint for Health). It is based on a managed care model which also encourages inter-departmental collaboration and consistency across programs. Increased inter-departmental collaboration and consistency across programs will be essential to managing all of Vermont's Medicaid spending under the cap.

Basic Structure of the Waiver

There are **several key elements** to the Global Commitment waiver. These include but are not limited to the following:

- The waiver imposes a global cap that limits Medicaid spending to a total of $4.7 billion over a five-year period.
- The waiver requires the state to establish itself as a public managed care company. State statute converts the Office of Vermont Health Access (OVHA), the state's Medicaid organization, to a public Managed Care Organization (MCO). AHS pays the MCO a lump sum premium payment in support of all Medicaid services in the state (with the exception of the Long-Term Care Waiver, SCHIP, and DSH, managed separately).
- The waiver provides the state with the ability to be more flexible in the way it uses its Medicaid resources.

One important implication of Vermont's decision to move to a premium-based financing structure is the opportunity to use "excess" premium revenue for fiscal relief. To the extent the premiums that OVHA receives are more than the cost of providing care to Medicaid beneficiaries, the state can use any "excess" premium revenue for a broad range of legislatively approved activities. Specifically, the state can use it for: (1) reducing the rate of uninsured or underinsured; (2) increasing access to quality health care for Medicaid beneficiaries, uninsured, and underinsured; (3) providing "public health approaches to improve the health outcomes and quality of life" for Medicaid eligible, uninsured, and underinsured; or (4) encouraging the formation and maintenance of "public-private partnerships in health care."

Waiver Goals

The goals of the waiver are the following:

- Increase access to care
- Contain cost of care
- Enhance quality of care

These goals will have specific, measurable, achievable, realistic, and timed (SMART) objectives that will assess and directly influence changes in access, cost, and quality during the life of the waiver (i.e., 5 years). In addition, our preliminary evaluation plan also includes by Years 2-5, implementing and enhancing *highly specific interventions* to favorably influence the aforementioned goals.

Evaluation

Section 1115 Medicaid waivers are intended to be research and demonstration programs that are evaluated to provide federal and state policymakers with information on the impact of changes implemented through waivers. One of the Terms and Conditions of the Global Commitment Waiver requires the State to conduct an evaluation of the Demonstration. The purpose of the evaluation is to determine whether the key goals for the waiver are achieved. The information learned from the evaluation is used to guide and inform both current and future planning. This evaluation is separate from, but linked to, the State's other quality assessment and improvement activities. The waiver evaluation goes beyond quality assurance, quality measurement, and performance improvement by evaluating areas of the demonstration other than those specified in the Quality Strategy.

AHS is interested in using the evaluation to identify effectiveness, successes, as well as, determining opportunities for improvement. In addition, the evaluation will incorporate different types of measures (e.g., financial, clinical, program, etc.) and have different targets (e.g., population groups, payers, providers, etc.). The State intends to secure a vendor through a RFP process that will conduct the evaluation with support from the Agency of Human Services and various Departments/Divisions within the Agency.

AHS has contracted with an EQRO to conduct the federally required review of Managed Care Entities as defined in 42 CFR 438 Subpart E. The EQRO will be contracted to perform the following activities for AHS as outlined in Table 1 below. Information from these activities will also be used as part of the analysis plan.

Table 1: EQRO Activities

ACTIVITY	REQUIREMENT
Prepare detailed technical report	Mandatory
Validation of Performance Improvement Projects	Mandatory
Validation of MCO performance measurements reported	Mandatory
Review to determine MCO compliance with standards	Mandatory

AHS developed the initial evaluation plan and will conduct the ongoing oversight, analysis, and monitoring. AHS will be responsible for the quarterly and annual reporting requirements.

Purpose

The evaluation will answer four fundamental questions:

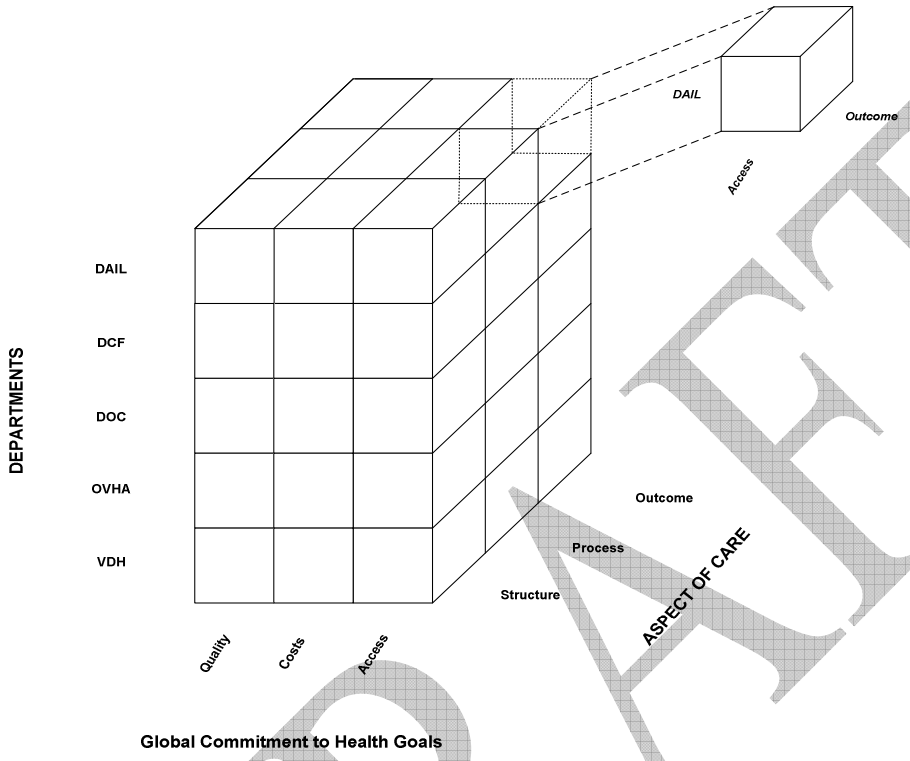
1. To what degrees did the demonstration achieve its purposes, aims, objectives, and goals?
2. What lessons were learned as a result of the demonstration? What would the state recommend to other states which may be interested in implementing a similar demonstration?
3. In what ways, and to what extent, were outcomes for enrollees, providers, and payers changed as a result of the demonstration?
4. Did the reallocation of resources in the demonstration generate greater "value" for the state's program expenditures?

Results of the evaluation will be compared within the state, with other states, and across time. The State intends to use the results of the evaluation to inform its future policy decisions with respect to the evolution of its healthcare system and policy planning efforts. In addition to the hypotheses being tested as part of this Evaluation Plan, the State will continue to monitor the program for its impact on the achievement of the Healthy Vermonters 2010 goals. While many of the above questions cannot be answered until the end of the demonstration period, the evaluation plan includes on-going information on the incremental progress of the demonstration; it is designed to measure changes before, during, and after the demonstration.

Section Two of the Evaluation Plan identifies the Evaluation Framework. The Framework lays out the State's proposal for assessing the impact of Global Commitment waiver on certain aspects of care (i.e., structure, process, outcomes) in several key areas (i.e., access, cost, quality). Section three of the Evaluation Plan describes the evaluation strategy. This section outlines the Formative and Summative evaluation activities included in the plan. It documents the short-term and overall impact of the waiver. Section four identifies the goals, objectives, and hypotheses being tested, as well as the indicators being used to monitor progress toward short and long-term goals. Section five documents the methods, procedures, data sources, and sampling methodologies to be used. The final section asserts the data analysis plan and discusses the reporting plans.

II. Evaluation Framework

The Global Commitment to Health waiver will use the Evaluation of Quality Rubric (EQR) evaluative framework depicted in Figure 1 to guide its development, implementation, and evaluation. The EQR Model is a modification of Hammond's EPIC Evaluation Model (Hammond 1973; Fitzpatrick, Sanders, & Worthen 2004), addressing the specific contextual (department), conceptual (Institute of Medicine Quality Domains), and quality framework (Donabedian's Aspects of Care) inherent to AHS mission and structure. The EQR Model facilitates the operationalization of the department goals and performance objectives, while providing a unified mechanism for assessing factors that influence the success or failure of specific activities at the department level and across the larger AHS. The EQR Model is efficacious for implementation approaches relying heavily on process evaluations, such as those currently conducted by AHS. The model also provides the structure for identification and assessment of the salient outcomes of the individual departments. Figure 1 depicts the 45 cells that may be recruited in designing the overall AHS evaluation. A brief definition of each dimension and respective cell components follows.



Departments

The following lists the characteristics of the individual departments comprising AHS.

• *Department of Aging and Independent Living (DAIL)*: The Department assists older Vermonters and people with disabilities to live as independently as possible. It provides support to families of children with disabilities to help maintain them in their home. It helps adults with disabilities find and maintain meaningful employment and it ensures quality of care and life for individuals receiving health care and/or long-term care services from licensed or certified health care providers. The Department also protects vulnerable adults from abuse, neglect, and exploitation; and provides public guardianship to elders and people with developmental disabilities.

• *Department for Children and Family Services (DCF)*: The Department for Children and Families (DCF) promotes the social, emotional, physical and economic well being of Vermont's children and families. It achieves this mission by providing Vermonters with protective, developmental, therapeutic, probation, economic, and other support services. To this end, DCF works in statewide partnership with families, schools, businesses, community leaders, and service providers.

• *Department of Corrections (DOC)*: In partnership with the community, the Department of Corrections supports safe communities by providing leadership in crime prevention, repairing the harm done, addressing the needs of crime victims, ensuring accountability for criminal acts and managing the risk posed by offenders. This is accomplished through commitment to quality services and continuous improvement while respecting diversity, legal rights, human dignity, and productivity. The Department manages offender risk in partnership with communities, operates correctional facilities for the disciplined preparation of offenders to become productive citizens, and supervises offenders serving sentences in the community and reintegrates offenders after release. The Department helps communities with Reparative Boards and Community Restorative Justice Centers to address victims' needs and provides opportunities for offenders to make amends for the harm done to the community.

• *Department of Mental Health (DMH)*: The Department oversees services to adults with mental illness and other mental health and emotional problems, and children and adolescents experiencing a severe emotional disturbance and their families.

- *Office of Vermont Health Access (OVHA)*: OVHA's mission is three-fold:
    - To assist beneficiaries in accessing clinically appropriate health services
    - To administer Vermont's public health insurance system efficiently and effectively
    - To collaborate with other health care system entities in bringing evidence-based practices to Vermont Medicaid beneficiaries
- *Vermont Department of Health (VDH)*: The Departments goal is to have the nation's premier system of public health, enabling Vermonters to lead healthy lives in healthy communities. VDH leads state and communities in the development of systematic approaches to health promotion, safety and disease prevention. VDH continuously assesses, vigorously pursues and documents measurable improvements to the health and safety of Vermont's population. VDH will succeed through excellence in individual achievement, organizational competence and teamwork within and outside of the Department of Health.

QUALITY

The degree to which programs/services and activities increase the likelihood of desired outcomes. The EQR Framework uses the Institute of Medicine health care quality domains as a guide.

Institute of Medicine Health Care Quality Domains

The six domains necessary for assuring quality health care identified by the Institute of Medicine (IOM, 2001) are identified below.

- *Effectiveness*: Effective health care provides evidence-based services to all who *can* benefit, refraining from providing services that are not of benefit

- *Efficiency*: Efficient health care is focuses on avoiding waste – including waste of equipment, supplies, ideas, and energy

- *Equity*: Equal health care provides care without variation in quality due to gender, ethnicity, geographic location and socioeconomic status

- *Patient Centeredness*: Patient centered care emphasizes a partnership between clinician and consumer.

- *Safety*: Safe health care avoids injuries to consumers from care that is intended to help

- *Timeliness*: Timely health care involves obtaining needed care and minimizing unnecessary delays in receiving care

ACCESS

AHS believes that all Medicaid enrollees must have access to comprehensive care. Access to care encompasses all aspects of accessibility including financial, geographic, physical, and communicative access. This means having health insurance, having appropriate providers, timely access to services, culturally sensitive services, and providing for second options as needed. Access to Care Standards were developed in response to the Global Commitment to Health Waiver. These standards use CFR 42 Access to Care Standards as a guide.

COST

All costs associated with providing programs/services and interventions to the Medicaid population of Vermont including money, time, and labor.

Aspects of Care

The Evaluation Framework also uses Donabedian's aspects of care (i.e., structure-process-outcomes) (Donabedian, 1980).

- *Structure*: Structure refers to components (e.g., organizational units, individuals) and their relationships to each other. Evaluating "structure" means determining the degree to which the necessary components and relationships are in place, operational, and of sufficient quality to produce the outcomes desired.

- *Process*: Process refers to what the components do. Evaluating "process" means measuring the level of performance of the components individually and of the system, program, or waiver as a whole.

- *Outcomes*: Outcomes refer to the results for, and impacts on, different parties (e.g., enrollees, providers, payers, and employers). Evaluating "outcomes" means measuring the results and impacts for each type of party. Financial Outcomes - Utilization and costs patterns of AHS clients. Clinical Outcomes - General and disease specific functional measures (e.g., health

status), events (e.g., myocardial infarction, hospital acquired infection, hospitalization), and surrogate markers (e.g., clinical depression - Hamilton Depression Inventory score ≥ 19.0). Humanistic Outcomes - Client perspective measures of day-to-day well being and functioning (e.g., quality of life) and experience in receiving medical care (ambulatory/inpatient care surveys).

Rarely are all 45 cells within the rubric of the EQR Model used in any evaluation study. Frequently, many cells prove irrelevant to a specific evaluation yet help in defining those cells that are most important. Thus, the EQR model will be useful in identifying department-specific mechanisms for implementing goals and objectives, and guide appropriate assessment activities for formative and summative evaluation.

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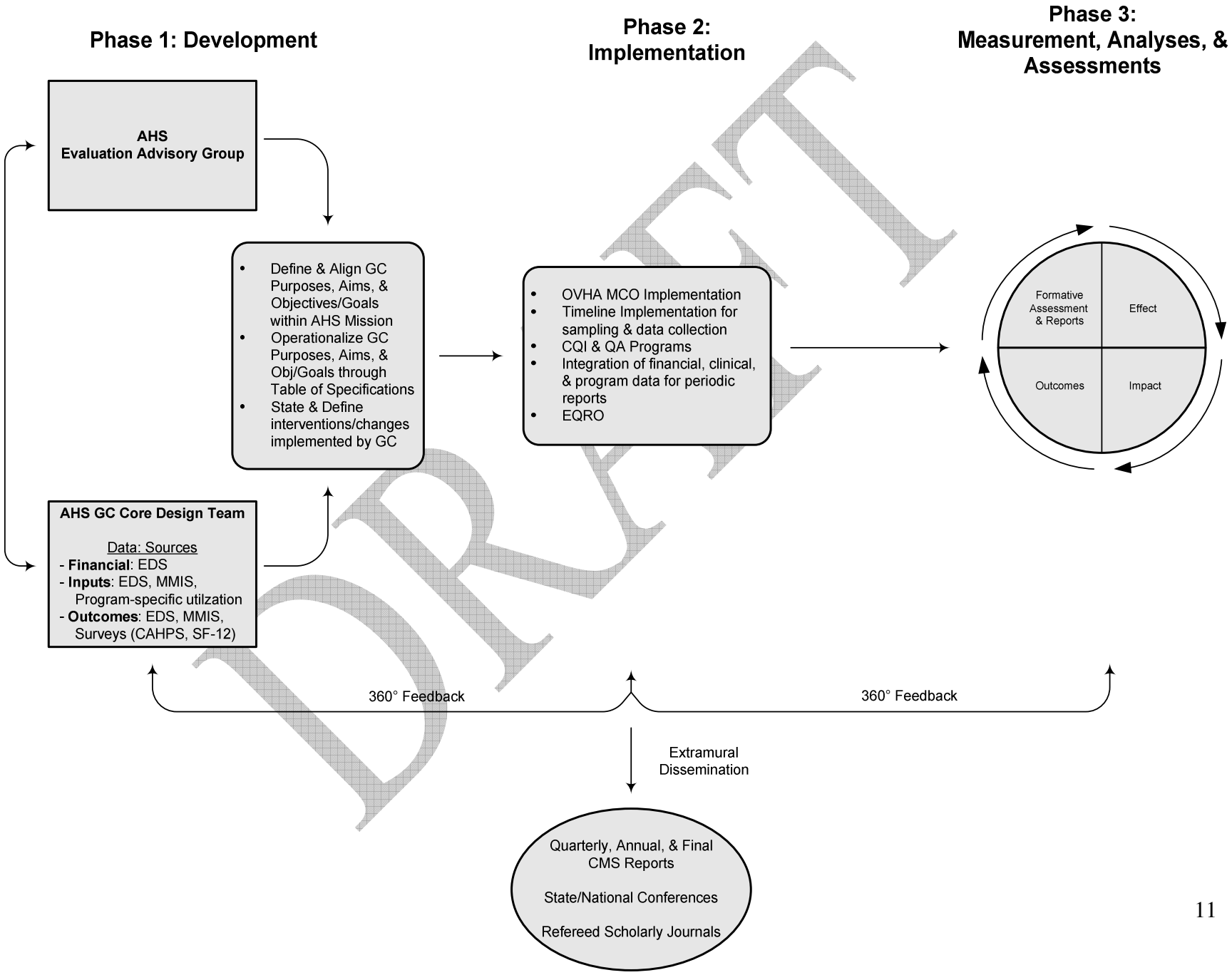
Figure 1: VT Global Commitment Evaluation



III. EVALUATION STRATEGY

In this section, we present a revised evaluation strategy—to be enhanced as the waiver evolves—designed to measure the degree to which the purposes, aims, goals, and objectives of the waiver have been achieved. The evaluation is designed to not only address the long-term impact of the demonstration, but to provide intermediate and short-term data on the progress of the demonstration as well. In addition to assessing the overall impact of the waiver, the evaluation plan will assess the impact of the innovative changes made possible as a result of the waiver. As a result, the plan utilizes both performance measurement results (providing more real-time data focused on whether a program is achieving measurable objectives) and more rigorous program evaluation findings that typically examine a broader range of information on the waivers performance. Broader waiver evaluation provides an assessment of whether the waiver achieved its overall goals as well as helps to identify adjustments that may improve its results. As a result, our data collection methodology is applied during all three phases of implementation (i.e., pre-implementation, implementation, and post-implementation). See process map attached.

To ensure that the waiver is implemented as intended and achieving the related goals/objectives and desired outcomes, the evaluation plan comprises both **Formative** and **Summative** designs and employs both qualitative and quantitative methods to collect and analyze data. The evaluation plan will not focus on outcomes exclusively, but is also interested in capturing any evidence that the waiver is building momentum toward: (A) increased access; (B) decreased cost; and (C) enhanced quality. In addition, both designs allow for feedback that is used to modify the implementation of the waiver and the programs/services/interventions or changes that happen as a result of the waiver as needed.

Formative Evaluation

Formative evaluation addresses whether the waiver was implemented as planned and is providing its intended goals, objectives, and outcomes. Results from our Formative evaluation activities will act as an "early warning system" alerting AHS to any deviations from the proposed plan. This information will directly influence decision-making by giving AHS early and frequent insights into any potential shortcomings, oversights, or problems that may result from waiver implementation. Documenting the waiver's development and operationalization will also provide AHS with an understanding of the reasons for successful or unsuccessful performance, provide direction in shaping program modifications and improvement and well as provide information regarding the generalizability of its findings.

Our Formative evaluation incorporates both *qualitative* and *quantitative methods* designed to answer the following questions: (1) is the waiver being implemented in the manner in which it was intended? (2) what types of deviations from the plan occurred (3) what impact did the deviations have on the objectives of the waiver and (4) what programs/services/interventions are being provided, to whom and at what cost?

In order to answer the above questions, data will need to be collected and analyzed to determine the relationship between actual and proposed accomplishments. Analysis will be conducted from a number of different prospectives. First, an Implementation Analysis will be conducted to determine if the waiver is being executed as planned. This analysis shall be based on semi-

structured, in-person interviews with key informants from the Departments/Divisions of AHS, as well as, community leaders, administrators, physician leaders, and others directly responsible for or knowledgeable about Managed Care Organizations and health care in Vermont. Data collection shall follow generally accepted principles for qualitative research. Common, structured interview protocols will be used to guide the in-person interviews with separate protocols constructed for respondents in different organizations. Next a Managed Care Analysis will be conducted to provide a profile of the MCO at different points in time throughout the evaluation. Information will be gathered through interviews with key informants in the MCO, a sample of their providers, and state officials. Information will also be collected re: number of enrollees by type and age, number and types of providers, enrollment and disenrollment numbers, and grievance/appeal numbers. Finally, a fiscal analysis will be conducted to monitor the waivers impact on program expenditures. As outlined above, data collection shall follow generally accepted principles for qualitative research. Second, information will be gathered from financial reports indicating the costs of service utilization by Medicaid enrollees by PCP, Specialist, ED visits, and inpatient stays.

To establish detailed, person-level data on the actual experiences of Medicaid recipients as they enroll in and receive care, the evaluation shall include a special study in which a relatively small sample of enrollees shall be identified and asked to participate in a series of interviews throughout their Medicaid experience. This shall include the eligibility determination process, enrollment, service delivery, and disenrollment, if applicable. All reasonable methods shall be used to ensure that the subjects for these special longitudinal studies include people of varying age, race, ethnicity, gender, and language groups. The intent is to provide information at a greater level of detail and depth, in order to complement the quantitative analysis that make up the three core project area described above.

The results of the Formative evaluation will be used to: provide program staff with specific goals for the month, quarter, or year, and/or provide direction in shaping modifications that may be required to implement a more effective waiver.

Summative Evaluation

In addition to the Formative evaluation described above, summative evaluation is used to demonstrate how the waiver has changed or improved the health and well being of the Medicaid population. Our Summative evaluation will answer the following questions: (1) Has the waiver increased access among enrollees? (2) Has the waiver reduced Medicaid costs? and (3) Has the waiver enhanced the quality of care for enrollees? In order to answer these questions, pre/post waiver implementation data that identifies the impact of the waiver on access, cost, and quality will need to be collected.

In order to be a success at both the macro and micro levels, the waiver must show that there were positive changes to access, cost, and quality that came about as a result of the waiver and/or its sponsored programs/services/interventions or changes. As a result, effectiveness of the waiver depends on its ability to address the factors in our communities that limit access, increase costs, and compromise quality. In an attempt to capture this data, the MCO is required to submit annual Performance Measurement data to AHS. Measures, Metrics, and Indicators will be use to

help define and measure progress towards the waivers ability to enhance quality of the care (including outcomes and consumer satisfaction), increase access to care, and contain the cost of care. The required performance measures are either HEDIS, or HEDIS-like measures (see next chapter for complete list of Performance Measures used). The MCO will also be required to report enrollee satisfaction based on the CAHPS model. Annual data will be tracked and trended over time (when available). In addition, inpatient and outpatient utilization, cost, and quality indicators for Medicaid enrollees before and after their enrollment in the Global Commitment to Health Waiver will be analyzed and compared to benchmarks and/or targets in order to assess the achievement of these goals. This analysis shall determine whether statistically significant differences exist year to year in access, cost, and quality.

In addition to determining if the activities really made a difference in the lives of enrollees, the use of performance measures will strengthen existing services, target effective services for expansion, and identify training needs. As a result, performance measures will show not only where the waiver and its sponsored services/changes are being effective for enrollees, but also where outcomes are not as expected.

Continuous Quality Improvement

The full value of any evaluation is only realized when it can provide ongoing feedback to the waiver and the affected population at large. As a result, flexibility and adaptability are institutionalized in the evaluation plans careful commitment and ongoing adherence to Continuous Quality Improvement, which assigns paramount priority to continuing improvement (not merely initial), needs assessment and ongoing monitoring and evaluation. AHS will regularly monitor the waiver on the key outcome measures and performance targets and make changes in the waiver that will improve achievement of the performance targets (obtaining CMS or legislative approval where needed). The information may include statistics related to program outcomes (quantitative data) or stories about a success with a client or organizing effort (qualitative data). If, in the course of the implementation of the demonstration, AHS finds that the demonstration is not performing as hoped on some of the measures, then AHS can make adjustments in the design and implementation of the demonstration (obtaining CMS or legislative approval where needed) in order to improve the performance of the demonstration in meeting its purposes, aims, objectives, and goals. When a problem or opportunity for improvement is identified, Department/Division leaders will objectively define the issue and share valuable feedback and provide recommendations for consensual changes in direction or improvement. Using the expertise of our Departments/Divisions and community partners, we will answer the following questions: what is causing the changes to be made, why the changes should be made, and what are the changes to be made (including the goals, objectives, responsibilities, and timelines). By answering these questions, AHS will be able to find out why the anticipated impact is not materializing and decide on a new approach to achieve the intended result. Subsequently, AHS will identify possible solutions, implement changes, as authorized, and collect additional data and information to see if the change had made an improvement. Modifications to the plan will be made to include the necessary changes. New versions of the plan will be disseminated to CMS while old copies will be filed for future reference. In real practice, this commitment will yielded a virtuous feedback cycle between and across our evaluation activities. Our evaluators will consistently focus equally on *Formative* and

Summative evaluation as a means of continually enhancing our programs and helping us course-correct our activities with maximum flexibility and adaptability. This process of regularly measuring, monitoring, and making changes should result in continuous performance improvement in the waiver in terms of achieving its performance targets and intended outcomes.

Timeline

The Global Commitment Evaluation will be implemented in a highly **integrated** manner: establishing evaluation design; determining the research method; identifying valid/reliable data; identifying and engaging stakeholders; collecting data; analyzing and interpreting data; report writing; and dissemination of findings. These activities—which are explained in greater detail in the subsequent section will be integrated under the direct supervision and oversight of QAPI Committee with day-to-day operational leadership from the AHS Quality Improvement Manager. Evaluation milestones include: **Milestone 1:** Establishing the evaluation design; **Milestone 2:** Determining the research methods; **Milestone 3**: Identifying valid/reliable data; **Milestone 4**: Identify/engage stakeholders; **Milestone 5**: Collect data; **Milestone 6**: Analyze and interpret data; **Milestone 7**: Write report; **Milestone 8**: Disseminate findings. The timelines in this plan indicate target dates. These milestones and the timelines will help focus and coordinate the efforts of our evaluation. We will use these milestones as a way of monitoring and *evaluating* our effectiveness in meeting both short and long-term objectives.

Below is a realistic pair of timelines for the evaluation project, showing key activities and milestones. The first timeline is detailed for Year 1 of the evaluation. The second is for Year 2.

Year 1: (6/30/08-6/29/09)

	Year 1 of Evaluation											
	Month:											
Activity/Milestone	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Establish Evaluation Design	x	x	x	x	x	x						
Determine Research Methods					x	x	x	x	x	x		
Identify Valid/Reliable Data							x	x	x	x	x	x
Identify/Engage Stakeholders										x	x	x

Years 2: (6/30/09-6/29/10)

	Years 2 of the Evaluation											
	Month:											
Activity/Milestone	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Collect Data	x	x	x	x	x	x						
Analyze and Interpret Data					x	x	x	x				
Write Report							x	x	x			
Disseminate Findings									x	x	x	x

IV. GOALS, HYPOTHESES, OBJECTIVES & PERFORMANCE MEASURES

Goals

The Global Commitment waiver and the interventions/changes implemented as a result of the waiver have the following goals:

- to increase access
- to contain cost
- to enhance quality

Access to Care: *How does waiver implementation affect beneficiary access to care?*
One goal of the waiver is to increase Medicaid beneficiary's access to primary care. While the waiver itself does not focus increasing the supply of healthcare workforce who provide affordable care, accept Medicaid patients, or practice in underserved areas, the evaluation will still seek to determine whether there was any change in a beneficiary's access to primary care. In addition to measuring Medicaid eligibility and enrollment and access to their primary care provider, the evaluation will also capture indirect measures such as emergency department visits, inpatient days, as well as non-reimbursable emergency department and inpatient care. Other ways to document the impact of the waiver on access to care might include the following: percent of beneficiaries assigned a primary care provider, percent of primary care providers per beneficiary per region, or percent of provider accepting Medicaid.

Cost of Care: *How does waiver implementation affect the cost of care?*
The second goal of the waiver is to contain (i.e., maintain or reduce) Medicaid spending. While the GC waiver does not seek to make any fiscal changes (e.g., to increase copayment requirements) or programmatic changes (e.g., to reduce the scope of covered benefits), it does assume that the impact of the waiver will be "cost neutral." This means that there is an expectation that the costs associated with providing care during the waiver will be no more than the costs of providing care without it. In addition to measuring the average expenditures per beneficiary, looking at the amount of money spent on acute care, home health care, and prescription drugs, as well as the amount of money spent on those with chronic conditions will help determine the impact of the waiver on the cost of care.

Quality of Care: How *does waiver implementation affect the quality of care?*
The final goal of the waiver is to enhance the quality of care. Methods used to determine quality include the review of the health care received by enrollees who were treated for a particular condition (e.g., childhood asthma, adult depression), the review of the standard of care provided to a particular group (e.g., immunizations for children 2 years of age), and examining beneficiaries experience of care. Currently, the Agency of Human Services (AHS) requires the Vermont Medicaid Managed Care Organization to report quality of care measures based on the Healthcare Effectiveness Data and Information Set (HEDIS) and the Healthcare Providers and Systems (CAHPS) Survey.

Hypotheses

AHS has developed a series of hypotheses with respect to the impact of the waiver on the broader health care environment, looking at issues such as the following: the impact of the waiver on the percentage of Vermonters who are uninsured, the impact of the waiver on the cost of in-patient care, and the impact of the waiver on enrollee satisfaction. In addition, a series of hypotheses have been developed about the impact of the waiver on Medicaid sub-populations targeted for coverage due to new programs/services/interventions or changes to existing processes or structure of care that were made possible as a result of the waiver. These hypotheses articulate the outcomes AHS expects as a result of the Global Commitment Demonstration.

AHS has developed a series of hypotheses about the impact of the waiver on the populations targeted for coverage under the waiver. The specific hypotheses to be tested in order to measure the changes/intervention success in meeting these objectives are presented in the following table:

Table 2: Waiver Hypotheses by Goal

GOAL	HYPOTHESIS
ACCESS	Introducing the waiver will result in positive outcomes as measured by individual access to the care.
COST	Introducing the waiver will result in positive outcomes as measured by cost of providing care.
QUALITY	Introducing the waiver will result in positive impacts as measured by quality of care.

In addition to testing the hypotheses described in the proposal, Vermont will continue its many activities directed at improving the quality of the program and the achievement of the Healthy Vermonters 2010 goals. The State has a long-term commitment to examining program results in an objective and unbiased manner. Where indicators show that the desired result is not being achieved, the State has a history of modifying the program to ensure a positive result over the life of the Demonstration.

Objectives

AHS has established distinct Specific, Measurable, Achievable, Realistic, and Time (SMART) objectives that are linked to the goals of the waiver. These objectives will be used to evaluate the performance of the waiver as well as drive agency-wide performance improvement efforts. Key objectives include, but are not limited to those contained in the following Table:

Table 3: Waiver Objectives by Quality Goal

GOAL	OBJECTIVE	FOCUS AREA
QUALITY	To increase enrollees rate of childhood immunizations by 10% over the next five years.	Immunizations
QUALITY	To increase enrollees rate of adolescent immunizations by 10% over the next five years.	Immunizations
QUALITY	To increase HgA1c and LDL screening by 10% over the next five years.	Chronic Care
QUALITY	To increase the use of appropriate medications for people with asthma by 5% over the next five years.	Chronic Care
QUALITY	To increase the rate of pregnant women receiving prenatal care by 5% over the next five years.	Prenatal Care
QUALITY	To increase the rate of children receiving well child visits by 5% over the next five years.	Children' Health
QUALITY	To increase antidepressant medication management by 5% over the next five years.	Behavioral Health
QUALITY	To increase consumers rating of satisfaction with health plan by 5% over the next five years.	Satisfaction
QUALITY	To increase enrollees rating of getting care quickly by 5% by 2010	Satisfaction
QUALITY	To increase enrollees rating of care received by 5% by 2010	Satisfaction
QUALITY	To increase enrollees rating of customer service by 5% by 2010	Satisfaction
ACCESS	To increase the percent of adults that had an ambulatory or preventive care visit by 5% by 2010	Prevention
ACCESS	To increase the percent of children 12 months-19 years of age that had a visit with a PCP annually by 5% by 2010	Children
ACCESS	To increase the percent of members receiving well child visits in the first 15 months of life by 5% by 2010	Children
ACCESS	To increase the percent of members receiving well child visits in the third, fourth, fifth, and sixth years of life by 5% by 2010	Children
ACCESS	To increase the percent of children 0-21 years of age that received EPSDT screening services by 5% by 2010	Children
ACCESS	To increase the percent of children and adolescents 2-21 years of age that had at least one dental visit annually by 5% by 2010	Oral Health
ACCESS	To increase the percent of outpatient visits/1000 member months by 5% by 2010	Prevention
ACCESS	To decrease the percent of ED visits/1000 member months by 5% by 2010	Prevention
ACCESS	To decrease the percent of Inpatient admissions/1000 member months by 5% by 2010	Prevention
ACCESS	To decrease the percent of survey respondents that indicated problems with getting care, tests, or treatment believed to be necessary by 5% by 2010	Satisfaction
ACCESS	To increase the percent of survey respondents that indicated getting the care they needed by 5% by 2010	Satisfaction
COST	To decrease the average annual cost of ED care of enrollees by 5% by 2010	Efficiency
COST	To increase the average annual cost of outpatient care of enrollees by 5% by 2010	Efficiency
COST	To decrease the average annual cost of inpatient care of enrollees by 5% by 2010	Efficiency
COST	To decrease the average cost of pharmacy care of enrollees by 5% by 2010	Efficiency
COST	To decrease annual percent of anticipated to actual costs by 5% by 2010	Efficiency

Performance Measures

The evaluation plan will incorporate the use of performance measures based on the following criteria: 1) evidenced based; 2) potential for improvement; 3) prevalence or incidence; 4) substantial impact on health status and/or health outcomes; and 5) to the extent possible the measures are adaptable across various practice settings. These measures will translate the goals of the waiver into concepts that can be measured and understood. The Global Commitment to Health waiver uses HEDIS as a guideline for its methodology to develop, collect, and report data for most of the targeted performance measures. Measures will be constructed from databases and analyzed using quasi-experimental pre-post designs. Using these constructed measures, we will determine whether efforts to improve access (e.g., eligibility, enrollment, primary care visits, ED visits, providers accepting Medicaid, etc.), enhance quality (e.g., immunization rates, appropriate medications for those with asthma, LDL screening, etc.), and decrease costs (e.g., pharmacy, inpatient, ED, etc.) were achieved. Survey data will be analyzed to describe trends in access and quality, while focus group data will be analyzed to demine changes in all three focus areas. The Table below shows a list of performance measures that could be used to determine the impact of the waiver.

Table 4: Performance Measures by Goal

	PERFORMANCE MEASURE	METRIC	SAMPLING METHODOLOGY	DATA SOURCE
QUALITY	Childhood Immunizations	Percent of children receiving childhood immunizations	Random Sampling	MMIS
QUALITY	Adolescent Immunizations	Percent of adolescents receiving adolescent immunizations	Random Sampling	MMIS
QUALITY	HgA1c and LDL Screening	Percent of enrollees receiving HgA1c and LDL screening	Random Sampling	MMIS
QUALITY	Asthma	Percent of enrollees receiving appropriate medications for asthma	Random Sampling	MMIS
QUALITY	Prenatal Care	Percent of pregnant women receiving prenatal care	Random Sampling	MMIS
QUALITY	Well-Child Visits	Percent of children receiving well child visits	Random Sampling	MMIS
QUALITY	Oral Health	Percent of enrollees receiving dental visits	Random Sampling	MMIS
QUALITY	Behavioral Health	Percent of enrollees receiving appropriate antidepressant medication management	Random Sampling	MMIS
QUALITY	Health Plan	Enrollees rating of satisfaction with health plan	Random Sampling	CAHPS
QUALITY	Quick Care	Enrollees rating of getting care quickly	Random Sampling	CAHPS

Table 4: Performance Measures by Goal (continued)

	PERFORMANCE MEASURE	METRIC	SAMPLING METHODOLOGY	DATA SOURCE
QUALITY	Rating of Care	Enrollees rating of care received	Random Sampling	CAHPS
QUALITY	Customer Service	Enrollees rating of customer	Random Sampling	CAHPS
ACCESS	Ambulatory Care	Percent of enrollees that had an ambulatory or preventive care visit	Population	MMIS
ACCESS	PCP Visit	Percent of children 12 months-19 years of age that had a visit with a PCP annually	Population	MMIS
ACCESS	EPSDT	Percent of children 0-21 years of age that received EPSDT screening services	Population	MMIS
ACCESS	Out Patient Visits	Percent of outpatient visits/1000 member months	Population	MMIS
ACCESS	ED Visits	Percent of ED visits/1000 member months	Population	MMIS
ACCESS	Inpatient Admissions	Percent of Inpatient admissions/1000 member months	Population	MMIS
ACCESS	Problems Getting Care	Percent of survey respondents that indicated problems with getting care, tests, or treatment believed to be necessary	Random Sampling	CAHPS
ACCESS	Getting Care Needed	Percent of survey respondents that indicated getting the care they needed	Random Sampling	CAHPS
COST	ED Utilization	Average annual cost of ED care of enrollees	Population	MMIS
COST	Outpatient Utilization	Average annual cost of outpatient care of enrollees	Population	MMIS
COST	Inpatient Hospitalization	Average annual cost of inpatient care of enrollees	Population	MMIS
COST	Pharmacy	Average cost of pharmacy care of enrollees	Population	MMIS
COST	Budget Neutrality	Annual percent of actual to anticipated costs	Population	MMIS

The performance measures give trend information, which provides guidance in designing focused interventions for quality improvement. Reported HEDIS rates can be benchmarked to NCQA Medicaid HEDIS means and percentiles. Measures are used to evaluate services to

subpopulations, including those with chronic conditions and special health care needs. Access and utilization measures assess primary and specialty care referral patterns to assure care is provided in the most appropriate, least restrictive setting. One important source of information to initiate and guide improvement efforts is consumers who report on their direct experiences with health care services. The most widely used instrument for collecting reports and ratings of health care services from the member's perspective is the CAHPS Health Plan Survey. CAHPS survey data allows entities to: 1) analyze performance compared to benchmarks; 2) identify changes or trends in performance; and/or 3) consider other indicators of performance.

Targets

The purposes, aims, and objectives of the waiver are translated into quantifiable targets for improvement, so that the performance of the waiver and the interventions/changes that result can be measured. Vermont has only one Managed Care entity that serves Medicaid recipients. Having no other comparable entity (s) on which to benchmark performance, Vermont will use national or state benchmark data for targeted indicators. Targets will be established using nationally accepted benchmarks or an average of program data. The use of targets will help monitor effectiveness of the waiver as well as the changes/interventions whose implementation was made possible by the waiver.

V. DESIGN, METHOD, PROCEDURE, DATA SOURCE

Design

Both qualitative and quantitative designs will be used to address the research questions. Qualitative designs will be used to better understand the process of waiver implementation. They will include the use of purposeful sampling, interviews, focus groups, and inductive analysis to discover patterns, themes, and interrelationships. Quantitative designs will be used to better understand the impact of waiver implementation (i.e., the relationship that waiver participation has on access, cost, and quality). They will include the use of probability sampling descriptive/inferential statistics, and deductive analysis to generate relationships between variables that are generalizable to the broader Medicaid population. Quantitative designs can be descriptive or longitudinal and either cross-sectional or longitudinal.

Method

The analyses will utilize a mixed method approach to evaluating the impact of the waiver.

Quantitative research and methods involves hypothesis testing, use of random sampling; use of structured data collection instruments; statistical data analysis, and generalizable findings. This type of research involves the use of tools, such as questionnaires or equipment to collect numerical data. The most popular data collection techniques include: surveys, secondary data sources or archival data, objective measures or tests, and interviews.

Qualitative research and methods involves hypothesis generation and the use of non-representative samples; use of unstructured or semi-structured data collection instruments; and non-statistical data analysis, non-generalizable findings. Common types of methods used include observations, in-depth interviews, and focus groups. Two types of interviews are used in evaluation research: structured interviews, in which a carefully worded questionnaire is administered; and in-depth interviews, in which the interviewer does not follow a rigid form In the former, the emphasis is on obtaining answers to carefully phrased questions. In the latter, however, the interviewers seek to encourage free and open responses, and encourage capturing of respondents' perceptions in their own words. A focus group is a small group selected for its members' opinions about or response to a particular subject or area. Due to the nature of this type of research, the design emerges as the waiver unfolds.

Procedure

Data is collected using a structured and systematic process to ensure that information given to or requested from subjects does not vary by staff member or program participant. Staff collects specific information on variables such as: client demographic attributes, and health status. In general, external factors are not expected to significantly affect the assessment of the hypotheses presented in this evaluation plan. However, where market conditions and other factors could have an impact, AHS will develop approaches to quantify and/or isolate the impact of such factors.

Instruments

Monitoring and evaluation rely on data collection instruments to elicit and record information. Existing data collection instruments will be used, when available. When appropriate, new data collection instruments will be developed. Various types of standard and/or developed data collection instruments (e.g., questionnaires, surveys, interview guides, etc.) will be used throughout all phases of waiver implementation.

Frequency

The evaluation plan will incorporate the use of both cross-sectional and longitudinal data. Information on selected measures will be collected prior to waiver implementation. Baseline data will be collected only once (prior to the implementation). Data on the same measures will be collected post waiver. This data will show the change as a result of the waiver. In addition, data will be collected on a monthly, quarterly, and annual basis during the course of the waiver. This data will show the how well the waiver is progressing towards meeting its goals.

Data Source

AHS will use a variety of sources and methods to test the above hypotheses, including beneficiary surveys and provider claims data. AHS staff and consultants will also analyze data from third party sources, such as the U.S. Census Bureau, for the purpose of measuring changes in the number of uninsured Vermonters over the life of the waiver, stratified by income and employment status. Data sources used to evaluate access to care include data obtained from the following:

- OVHA (encounter and utilization)
- State Medicaid information system files that include eligibility and enrollment data (ACCESS)
- Consumer Assessment of Health Plan Surveys (CAHPS) of a sample of each plan's enrollees
- BISHCA (2005, 2008, and 2009 VHHIS data)
- Vermont Medical Society (information on providers by region)
- Vermont Association of Hospitals and Health Systems (hospital ED data)

V. DATA ANALYSIS & REPORTING

Data Analysis

Our data analysis will consist of both exploratory and descriptive analysis strategies and incorporate univariate, bi-variate, and multi-variate analysis. SPSS software will be used to systematically apply statistical and/or logical techniques to describe, summarize, and compare data within the state, with other states, and across time.

Descriptive Statistics

Descriptive statistics are used to describe the basic features of the data. They depict what is or what the data shows. They provide simple summaries about the sample and the measures. Together with simple graphics analysis, they form the basis of our quantitative analysis of data. They are also used to provide simple summaries about the participants and their outcomes. An exploratory data analysis is used to compare many variables in the search for organized patterns. Data will be analyzed as rates, proportions, frequencies, measures of central tendency (e.g., mean, median, mode), and/or qualitatively analyzed for themes.

Inferential Statistics

Inferential statistics will be used when we are trying to reach conclusions that extend beyond the immediate data alone. Fundamentals statistics will be used to describe draw inferences about the populations from which they were drawn.

Reporting

In quarterly, annual, reports, AHS will describe results of the formative and summative evaluation methods outlined earlier. In addition, a final report will include the aforementioned information, but will also include an analysis of pre/post-test access, cost, and quality data. This reporting format will allow interested parties to differentiate the incremental and overall impacts of the waiver. Numerous strategies will be used to communicate evaluation findings (e.g., annual reports, website, and community meetings). Reports will be presented at meetings as well as distributed to AHS Departments/Divisions, and more broadly to AHS Community Partners. Reports will be written so as to be readily understood by a variety of audiences and populations, including the special needs populations we serve. Broad dissemination will occur via mailings as well through AHS's website. In addition, presentations will be given at staff meetings and to health care providers at regular meetings.